Canakinumab (Ilaris)

Provider Order Form rev. 3/25/2022

IVX HEALTH

PATIENT INFORMATION

Date:	Patient Name:		DOB:
ICD-10 code (required):		ICD-10 description:	
☐ NKDA Allergies:			Weight lbs/kg:
Patient Status: ☐ New to Therapy	☐ Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

THERAPY ADMINISTRATION

☑ **Canakinumab (Ilaris)**

For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis.

☐ 4mg/kg (with a max of 300mg) for patients with a body weight greater than or equal to 7.5kg subcutaneous every 4 weeks

For Cryopyrin-Associated Periodic Syndromes (CAPS)

☐ 150mg for patients with body weight greater than 40kg subcutaneous every 8 weeks

☐ 2mg/kg for patients with body weight greater than or equal to 15kg and less than or equal to 40kg subcutaneous every 8 wks

For Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever

Body weight less than or equal to 40kg

☐ 2mg/kg subcutaneous every 4 weeks

☐ 4mg/kg subcutaneous every 4 weeks - consider if clinical response not adequate.

Body weight greater than 40kg

☐ 150mg subcutaneous every 4 weeks

☐ 300mg subcutaneous every 4 weeks - consider if clinical response not adequate.

Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

☑ TB status & date (list results here & attach clinicals)
_____

OBSERVATION (PLEASE SELECT BELOW)

☐ Patient is required to stay for 30 minutes observation period

☐ Patient is NOT required to stay for observation time

☐ Other: _____

SPECIAL INSTRUCTIONS

_____

Prior to initiating immunomodulatory therapies, including ILARIS, patients should be evaluated for active and latent tuberculosis infection.

Provider Name (Print) | **Provider Signature** | **Date**

FAX NUMBERS

Fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ SOUTHWEST FL: 813-283-9144
☐ CHARLOTTE: 336-663-0143	☐ HARRISBURG: 844-859-4235	☐ ORLANDO: 844-946-0867	☐ TAMPA: 844-946-0849
☐ CINCINNATI: 844-946-0868	☐ HARTFORD: 860-955-1532	☐ PALM BEACH: 561-768-9044	☐ WEST TN/AR: 888-615-1445
☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ PHILADELPHIA: 844-820-9641	☐ MIDDLE TN: 888-615-1445
☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ SARASOTA: 941-870-6550	☐ EAST TN: 615-425-7427